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An Address.[1]

By Arthur T. White, C.M.G., V.D., L. & L.M.R.C.P., L.R.C.S., L.A.H.,

Retiring President of the Western Australian Branch of the British Medical Association.

In taking office as President last year, I emphasized the importance of certain diseases, especially malaria, bilharziosis and venereal diseases, which had been brought back by returned soldiers and which were liable to spread throughout the State. However, with the present system of notification and means adopted by the health authorities for combating these diseases, it is hoped that before long a considerable decrease in the numbers will eventuate. I now wish to touch briefly on these and other diseases which are of vital importance to the public and like the poor "are always with us."

The treatment of malaria seems to be narrowing itself down to quinine administered either by the mouth, intra-venously or intra-muscularly.

Liver troubles with extensive destruction of liver tissue sometimes occur through quinine making its way from the alimentary canal. Arseno-benzol has not been followed by the success that was anticipated In the vast majority of returned soldiers the benign tertian parasite has been found; also in the majority of recurrences.

This year a perfect plague of mosquitoes has been experienced and every endeavour should be made to exterminate the pest. Fortunately the less dangerous variety has been most in evidence, but should malaria once get a footing, a vast amount of suffering would ensue.

Bilharziosis, as you are aware, is giving our profession much anxiety and vigorous steps are being taken to minimize the ravages of this disease. With the treatment by tartar emetic it is hoped to eradicate the disease completely.

Many patients present themselves suffering from anæmia, debility, loss of weight, etc., without any definite reasons. Bilharziosis must not be lost sight of as a possible cause, particularly if the patient be a returned soldier.

The cystoscope, of course, lends valuable aid to the discovery of lesions.

You are all aware of the ravages venereal diseases caused in the ranks of the Army and the evil effects of transmission will be felt for many years in Australia in the form of invalidism and sterility. It is, therefore, desirable to assist in every possible way the stamping out of the scourge.

Many women will doubtless present themselves for treatment suffering from ovarian and uterine diseases, which you will be able to trace to gonorrhœa or syphilis and no doubt a great number of syphilitic children will be added to the burden of the community.

Every endeavour should be made to educate the public as to the dangerous nature of the disease and many medical men are busy educating school teachers and members of institutions to assist in the dissemination of literature regarding the many evils due to the disease. With our present knowledge of syphilis it ought not to be long before a decided check is put on the spread of the disease and by skilful treatment patients might be allowed to marry after a proper course of injections, etc..

We all know what misery is caused by the fact that by many of the laiety the disease is supposed to be incurable; melancholia, drunkenness or suicide is a frequent result.

Now that free clinics have been opened at our public hospitals, there is no necessity for concealment of the disease. It means, of course, that every taxpayer is paying for the misdemeanours of others, but in the interests of the community this ought not to be considered.

I will just refer to tuberculosis which claims so many victims each year. It is a subject for the consideration of every practitioner and should not be left to the specialist only. By the endeavours of the child welfare movement, by preventing young men and women from being driven to hard work beyond their powers and by protecting the adult worker from the more evil consequences of his labour by securing proper conditions in the mines, workshops and factories, a large percentage of tubercular cases might not develope.

This work not only concerns medical officers of health, but should be supported by every medical man in his endeavour to minimize the evils of the disease. The economic aspect must be considered. What are the chances that a child born and reared in a tuberculous family will not acquire the disease which, according to a considerable majority of authorities, is definitely communicable? Either the child should be removed from its infected relatives or the latter should be removed from it.

Sanatoriums are often inadequate to deal with all the patients and those in the advanced and most dangerous stages remain at home to infect the children. Undoubtedly village settlements would be beneficial, but the cost would be enormous and the difficulty of getting patients to remain in them would be great.

The recent war has revealed the number of physically defective men who were unfit for active service. These defects could not have been due to poverty in such a country as this; therefore they are in most cases preventible.

In order to build up a strong race, children should be thoroughly inspected and all defects, such as adenoids, enlarged tonsils, defective teeth, errors in sight, discharge from ears, should be treated. One most important matter, the proper feeding of infants, must be recognized. Too much reliance is placed by mothers now on artificial foods, which save the necessity of nursing as Nature intended.

Advice is often sought by patients as to the effect of physical training on their children and their fear of dilatation of the heart occurring. This condition

[1] Read at the Annual Meeting of the Western Australian Branch of the British Medical Association on March 20, 1921.

is more likely to be brought about by want of regular exercise than by constant work and we know that the healthy individual is not injured in any way by hard muscular work, provided that an excessive pace is not adopted. Medical men are largely responsible for keeping the attention of the public and governing bodies to these causes of physical defects and for insisting that proper steps be taken for their prevention.

I would like to refer to specialists. Owing to the rapid expansion of knowledge within the last few years, specialism is becoming the feature of the day and it must be admitted that no one man can acquire expert knowledge in all cases that present themselves in the daily round of a general practitioner. I believe that a man who feels that he has a special talent for a particular branch of the art, would be wise in selecting a special subject for study after he has been through the multifarious work of a general practitioner.

The place of the radiologist has come to stay and almost every day one finds the necessity for his work to assist diagnosis and help minimize the pain which used so often to be caused by examination of fractures without an anæsthetic.

What an enormous amount of suffering has been spared by the radiologist in locating foreign bodies during and since the war! Without his assistance it would be impossible to locate many bullets and fragments of shell and the probe would often have to wait for the development of a suppurating track to indicate their position.

Orthopædic surgery has been given a great impetus lately and a wide field is open for those who seek to restore the functions of injured muscles and nerves. Specialists in this branch ought to have a busy time in the future.

Judging from the results at the Base Hospital, many patients who would have been considered hopeless in the past, are now fitted for work and able to take their places in the ranks of useful citizens. I understand that our public hospitals are woefully deficient in plant and every endeavour should be made to have as complete an outfit as possible in order to give the best results and due credit to the specialists concerned.

Last subject, but not least. Let me say a few words on the military medical service. In view of the fact that a new organization for the military medical service is shortly to come into operation, I would strongly urge all young medical men to undergo a course of training in order to fit themselves for any future emergency.

As most of you are aware, field ambulances are officered by medical men and the whole success of these valuable units depends on the efficiency of the officers. Therefore, it is necessary that all those who intend to join, should attend camps of training and qualify for the various duties to be performed.

You all know how few trained medical officers took the field in the last war and with what signal success their work was credited. Remember this was only possible through their pre-war training and the numbers who had any experience were very few. However, I hope in the future that many will take advantage of the training and thereby prove their utility, should their services be required.

The sacrifice of time your country asks of you is not great and the time spent could be made both useful and recreative.

It is impossible to train a man in a short time and no war can be carried on successfully without a reliable and complete medical service.

The regimental medical officer is an important individual in war time, his duties requiring a knowledge of water supplies, hygiene and sanitation, camp inspections, as well as billets, huts, ablution places, kitchens, food, clothing, training of stretcher-bearers, as well as his medical work and prevention of sickness and general care of men in camp and on the march. Such duties can only be learnt in times of peace and not during the excitement and bustle of active service.

With vaccination and inoculation men must be up to date and throw their whole soul into the work in order to be a credit to themselves and the profession.

You all remember the splendid work of the teams in regard to blood transfusion. Special study should be made of this means of prolonging life.

In conclusion I would ask the members to take a lively and earnest interest in all matters concerning the welfare of the Branch and particularly to watch over the difficulties that at times assail the country members, who often think that because they are far away from the centre, no interest whatever is taken in their movements.

If a typed copy of each lecture with discussions could be sent to each country member it would materially aid him in keeping in touch with the centre. The country member is often quite ignorant of the proceedings at meetings and unless he sees extracts in the journal, remains ignorant of many important matters which affect his welfare.

I wish to thank you all for giving me such a patient hearing and express my gratification at having been honoured by your appointing me President for the last year.

It has been a great pleasure to me to have had your confidence, but I am afraid I have not always carried out the duties successfully.

THE TREATMENT OF ACUTE ANTERIOR POLIOMYELITIS.

By **Wilfred Vickers, D.S.O., M.B., Ch.M. (Syd.),**
Honorary Assistant Surgeon, Honorary Director of the Department of Massage and Medical Gymnastics, Royal Alexandra Hospital for Children, Sydney.

These few notes are written in the hope that a few practical details in the treatment of infantile paralysis will be of service at the present time. If I merely reproduce the ideas of Robert Jones and others, my excuse is that my experience at the Royal Alexandra Hospital for Children shows that the principles stated by them are not universally known.

The main factor in the treatment of infantile paralysis is relaxation of the affected muscles. In the older method of treatment, before splinting was suggested, rest in bed in the recumbent position was thought to be sufficient. I think that the best argument against that method of treatment is obtained from a study of the muscles which most frequently

remain paralysed after it has been applied, *viz.*, the dorsi-flexors and invertors of the foot, the external rotators of the thigh, the abductors and internal rotators of the arm. In the ordinary position of rest in bed these muscles are all stretched. Might not the statement that these muscles are the most frequently attacked and the most difficult to cure be to some extent a fallacy born of the old inadequate method of treatment? However, with adequate splinting to prevent stretching of these muscles, we see fewer of these deformities to-day.

A.—Trunk Muscles.

As a rule, complete rest in bed, with the back slightly arched, is sufficient.

B.—Muscles of the Lower Limb.

In complete paralysis of the lower limb, a back splint with a small pad behind the knee, to keep it slightly flexed, a foot-piece to keep the foot at right angles and a cross-piece to prevent rotation of the whole limb will meet all the indications. This needs to be varied as certain groups of muscles recover. Frequently it is found that there is early recovery of the plantar-flexors of the foot and sometimes these muscles are acting strongly. In these cases I have found the ordinary back-splint with foot-piece quite useless unless constantly supervised by a trained person. In these cases I use adhesive plaster, brought from one side of the leg, just below the knee, under the sole over the heads of the metatarsal bones and up on the other side of the leg and secured by two cross-pieces so arranged as to produce no constriction of the leg. In other cases a well-fitting plaster of Paris casing or celluloid splint is to be preferred. When the child can walk, and before the boot and iron stage, a walking plaster is often useful. Inversion and eversion, according to the necessity, can be applied.

Coming to the thigh, the quadriceps and hamstrings have to be treated. The quadriceps is one of the muscles that frequently remain weak. Here again we have an example of a stretched muscle, because, after a few weeks, the patient is often allowed to sit up in a chair with the knees bent. After the back-splint stage a calliper is the best treatment for these groups of muscles.

The external and internal rotators, flexors, etc., of the thigh can all be controlled by these means and they should be carefully watched, in order that relaxation may be provided for them.

C.—Upper Limb.

In the stage of complete paralysis, the position of abduction to a right angle at the shoulder, with the muscles of arm, forearm and hand in the mid-position is satisfactory. Care should be taken to prevent stretching of the internal rotators of the arm, which is most likely to occur when the arms are merely pinned to the pillow above the head. The "aeroplane" splint fulfils all requirements. It consists of a body-piece and a bar at a right angle, the angle fitting into the axilla. The bar is jointed at the elbow and ends in an expanded piece that can be used to flex or extend the wrist and fingers and thumb. In this connexion I think the mid-position, *i.e.*, the forearm on the same level as the shoulder, is the most suitable, unless the external rotators are affected more than the internal. In that case the splint can be made with the piece for the forearm to bend upwards at an angle of 45° with the arm-piece. With this splint flexion and extension of the forearm and wrist and pronation and supination can be controlled as required and more or less allowed as recovery takes place.

After all pain and tenderness are gone from the muscles, the splint can be removed and an attempt made at minimal movement. Special care must be taken that no stretching of affected muscles is allowed. The effect of gravity must be completely eliminated in these early movements and the limb must be placed in such a position that the muscle is only called upon to act through a very small angle. For example, for the deltoid the patient should be lying on his back, with the arm on some smooth surface (a polished board is the best). The arm is lowered about 10° and the patient makes an effort to pull the arm back. Should this be impossible, even with assistance, the splint is re-applied and another attempt made three or four days later. Another method that can be used in the case of the extensors of the hand is to hold the hand in the position of complete dorsi-flexion and to ask the patient to try to retain it there when the support is removed. The muscles will be felt to contract.

As movement returns, the muscle must not be fatigued or stretched. Later, massage can be used with the gentle movements suggested; but I do not think that electricity does any good. It is certain that both do harm if applied too early.

The time when splints should be discarded is difficult to fix; but I consider that it is better to retain them until the muscle can do its work against the effect of gravity.

In very severe cases I think that the splints should be retained for at least a year before the surgeon concludes that no more recovery will take place. I have known cases of paralysis of the quadriceps of many months' standing, in which a considerable amount of power has been recovered when a calliper has been provided. I have had cases of paralysis of the anterior tibial group, producing a marked equinus, in which recovery of the power to lift the foot followed after tenotomy of the *tendo Achilles* and over-correction of the foot for a few months, notwithstanding the fact that the acute attack had occurred three or four years previously.

A NEW TEST OF RENAL EFFICIENCY.

A Preliminary Report on the Results of Application of the Urea Concentration Test (MacLean) to Cases of Urinary Surgery.

By **Robert J. Silverton, M.B., Ch.M. (Syd.), F.R.C.S. (Ed.),** *Sydney.*

In 1919 Hugh McLean published a lengthy report on war nephritis,(1) in which regarding the question of prognosis and treatment, he emphasized the fact that clinical signs are not sufficiently early guides and moreover are often unsure ones. Cases of acute nephritis which do not completely resolve but go on to a chronic course, fall as a rule into either the

azotæmic or hydræmic group according to whether there is nitrogen or chloride retention in the blood. These types correspond more or less closely to chronic interstitial and chronic parenchymatous nephritis respectively. In the azotæmic (interstitial) type it was found that when urea is taken by mouth in large amount, the kidneys fail to concentrate it in the urine to the same degree as healthy organs.

The basic idea of the test is not new, for a similar but altogether impracticable test has been used for some years by the French in the form of what they term "the search for the maximum concentration of urea."

In order to discover the highest point to which a healthy man could concentrate urea in the urine, Ambard originally used the plan of putting the patient on a salt-free diet, restricting fluids a good deal and administering urea by mouth in repeated fractional doses. He discovered that this was not a convenient method. Later on (in 1913) working with Legueu and Chabanier(2) he evolved a diet consisting of the coagulum of milk, freed from whey and flavoured with sugar. On this diet (highly nitrogenous and salt-free) the subject suffered from no urgent thirst and on about the third day the maximum concentration of urea was reached. This point was found to be 5% to 5.6% in healthy individuals; when the kidneys were diseased the maximum point was lowered. The test is a very valuable one in itself, but is of course entirely unsuited for practice. The French themselves admit this and prefer in practice to measure the blood urea or work out Ambard's ureo-secretory constant.

MacLean has, however, studied the variations in the concentration of urea in the urine immediately after the ingestion of a known weight of this substance and has evolved what he terms the "new urea concentration test" which may be considered as a modification of the French test, but infinitely more convenient in practice. Fifteen grammes of urea are given by mouth, dissolved in 100 c.cm. of water to which are added a few drops of tincture of orange. The urea percentage in the urine quickly rises in health, but since during the first hour the reading does not reach its maximum point on account of diruesis caused by the urea, only the urine of the second hour is tested. The first hour's specimen is discarded.

MacLean states that a concentration of 2% or over may be taken as evidence of efficient kidneys. A concentration of 1.5% indicates moderately efficient kidneys, while 1% or less means very inefficient organs.

The test was applied extensively by MacLean in medical cases and found to be of the highest value in the prognosis of the azotæmic type. While the readings were distinctly lowered in the latter group, they were unaffected in the hydræmic (chloride retention) type. This applies to the chronic stage; during acute exacerbations the readings were decreased in both types. Of course there are mixed types of chronic nephritis in which both the chloride output and the urea concentration are lowered.

While working during the first part of 1920 as senior house surgeon to the St. Peter's Hospital for Urinary Surgery, London, I was permitted to apply this test in surgical urological cases. I could discover no report on the results of this test in surgical cases, but considered that as a modification of the valuable but inconvenient French test above described it should prove of distinct use in urinary surgery. The type of nephritis occurring in kidney destruction due to surgical diseases of the organs themselves or to the back pressure of lower urinary tract obstruction is almost always azotæmic. The hydræmic element, characterized by œdema is very rarely seen. Therefore the urea concentration method is a test of excretion eminently suitable to surgical urinary cases.

On applying the test first of all to healthy people I found that the reading usually rose to the neighbourhood of 3% during the second hour after the ingestion of the urea. In disease the reading was lowered in proportion to the extent of renal damage. The lowest reading obtained was 0.65%. This was in the case of a man whose kidneys proved at autopsy to be very extensively destroyed. The cause was back pressure due to enlarged prostate.

In applying the test certain precautions are absolutely necessary. These are not mentioned by MacLean, but as they are very important I shall describe them. The reading may be seriously influenced by the composition of neighbouring meals and even more seriously should the patient ingest any fluids or solids before or during the test. In all the cases I tested a fixed routine was adopted in order to keep the method as uniformly accurate as possible. A breakfast of 230 c.cm. (8 ounces) of tea and one round of buttered toast was given at 8 a.m.. At 10 a.m. the 15 grammes of urea dissolved in 100 c.cm. of water were taken. Except this nothing was eaten or drunk from breakfast until 12 noon, that is until after the collection of the second hour's urine had been made. In this manner all disturbing influences are avoided and this is the routine I would recommend to surgeons who may desire to employ the test. Forty-four cases of various types of prostatic obstruction were submitted to the test, as well as four cases of renal tuberculosis, one case of calculous pyonephrosis and two cases of urethral stricture. The results were briefly as follows:

(1) In Urethral Obstruction.

In this group the value of the test was found, unfortunately, to be definitely limited. Catheter collection of the urine is of course impossible and the occasional presence of residual urine in the bladder falsifies the readings by lowering them. The presence of residual urine in stricture is denied by some, but there is no doubt that it is occasionally present, even in large amount.

(2) In Prostatic Obstruction.

The collection was made by a catheter in the bladder. The test was definitely proved to be of value by noting the post-operative histories of the patients, and in the fatal cases by microscopic and macroscopic examination of the kidneys removed at autopsy.

All types of prostatic case were studied, just as they came up for diagnosis and yet nearly one-half gave readings of 2% or over. Nearly all the latter group

of patients were subjected to one-stage prostatectomy with happy results. The fad, then, of performing a two-stage operation in all prostatic cases, is not justified by necessity. The results of my investigations tend to show that with readings down to 1.7%, the operation may be completed in one stage. All these remarks, of course, only concern the kidney risks of operation; these are the greatest risks, but it must not be forgotten that they are not the only ones. Where the readings are between 1% and 1.7% preliminary cystostomy is advisable, but when the reading is below 1% even a preliminary cystostomy must not be risked at the outset. In such severe cases careful catheter drainage should precede the cystostomy, the latter intervention being withheld until the functional level becomes moderately increased.

(3) In Renal Diseases.

The collection is made by catheterizing the ureter of the less diseased or presumably healthy side. Rarely both sides have to be catheterized. Before nephrectomy is allowable the test should give a reading of 2% (preferably more) from the opposite kidney; the latter organ should be cytologically and bacteriologically free from disease.

The new test proved to be quite reliable at this level, the truth of its indications being amply confirmed by operations in the renal cases tested.

My conclusion is that the urea concentration test may be considered as a valuable addition to the urologist's armamentarium. Its value in surgical urinary cases is even more general than in the "medical" nephritides, as the latter are not always of the azotæmic type. Tests of retention (*e.g.*, blood urea) still hold their place, of course, and are necessary in stricture cases, while advisable as a check on tests of excretion in prostatic cases. In renal diseases, tests of retention are of very doubtful value on account of the phenomenon of compensatory hypertrophy on the undiseased side.

As a test of excretion, the new urea test does not displace the phenol-sulphonephthalein test, which gives more finely graduated estimations of renal damage. Certain fallacies, however, which vitiate the results of the phthalein test (catheter blocking, extra catheter leakage in renal cases and the presence of blood) do not affect the result of the new urea test, as it is purely a test of concentration.

I desire to acknowledge my great indebtedness to the surgeons under whom I worked at the St. Peter's Hospital, for the opportunities they gave me of pursuing this investigation of their cases and for their encouragement while I was engaged on the work.

References.

(1) H. MacLean: "Albuminuria and War Nephritis," Med. Research Comm. Report, London, 1919.

(2) L. Ambard: *"Physiologie normale et pathologique des reins,"* Paris, 1920.

Reports of Cases.

SOME ILLUSTRATIVE CASES OF DUCTLESS GLANDS THERAPY IN THE INSANE.[1]

By **James Bentley, M.C., M.B., B.S. (Edinburgh),**
Assistant Medical Officer, Hospital for Insane, Claremont, Western Australia.

In publishing the following cases, which have been treated by ductless glands, I do so chiefly with the object of stimulating others to investigate this line of treatment. The first three cases are cases of *dementia præcox*. Although Case III. bears some close similarity to acute melancholia, on the whole it is considered to be a case of *dementia præcox*. The treatment of these cases was encouraged by the work of Dercum and Ellis, who examined *post mortem* eight patients the subjects of *dementia præcox*. All these patients had died from tuberculosis. In seven the thyreoid was under weight. There were variations in the adrenals. They state that their findings are in keeping with the inference that anomalies exist in the ductless glands in *dementia præcox*.

Generally speaking, there are two groups of ductless glands, one of which are accelerators, which consist of the thyreoid, pituitary, adrenals and reproductive glands. The second group are retarders and comprise chiefly the pancreas, parathyreoid and possibly the thymus glands.

The chief work in this institution has been done with the accelerator group, as the following cases show; but it is now intended to try the retarding group in maniacal cases.

Hormotone.

CASE I.—B.L.A., aged 28, was admitted on May 31, 1919. The certificate set out that he would not speak, smiled inanely, stared fixedly into space, at times refused food, but would give no reason, showed little sign of intelligence, seemed fearfully depressed about something, behaved peculiarly. He had a similar attack about six years ago, but got quickly better. He was a well developed man; his height was 177.8 cm. and his weight 64.4 kilograms. His organs were all healthy and his reflexes were normal.

On admission he took food well, lay listlessly in bed and paid no attention to his surroundings. He would not reply to questions, although he showed that he understood what was said to him by protruding his tongue when asked to do so. On June 15, 1919, he was in a cataleptic condition; he resisted his limbs being moved and if they were placed in any particular position, he would hold them in that position for a long interval. Later the catalepsy disappeared, but he had not spoken since admission. He refused food at times and required to be kept in bed continually, because he was so dull.

On September 9, 1919, he was put on hormotone and ten days afterwards he spoke a little for the first time since admission and expressed the delusion that his bowels were blocked.

On September 27, 1919, he was conversing freely and was up and about and a month later proved to be an extremely useful worker in the hospital, but was still slightly dull.

On December 29, 1919, he was discharged as recovered.

His father reports that he has kept well and worked on the farm since his discharge, but that he is affected by the heat and he is rather reticent; otherwise he can notice nothing the matter with him. He is in a somewhat similar condition to that in which he was previous to admission. He is still taking hormotone three times a day.

CASE II.—F.H., aged 44, was admitted on December 2, 1919. The medical certificate sets out that he was very depressed, restless and troublesome and at times had to be restrained. He heard voices which told him [illegible] was bad morally. He saw visions of insects and animals crawling about and had delusions that he was suffering from leprosy. Except for a systolic murmur in the mitral area, his organs were healthy.

On admission he was very depressed and miserable and it was difficult to get him to answer questions; he would only reply in monosyllables. He was very confused and at night he was restless and slept badly. He heard a voice

[1] Read at a Meeting of the Western Australian Branch of the British Medical Association on March 20, 1921.

and said that the same voice talked to him continually, but he did not know to whom it belonged. A week later he was in a state of catalepsy. He took no notice of his surroundings, resisted having his limbs moved and held his limbs in any position in which they were placed for a considerable time. He would not speak, refused food at times and had to be fed.

On December 20, 1919, he was put on hormotone and a week later the cataleptic condition had disappeared; but he still heard voices.

On December 30, 1919, he conversed freely and took food well.

On January 20, 1920, he was considerably improved, talked freely, ate well and worked in the ward. At this time the hormotone was reduced to one tablet thrice daily, as he was becoming rather excitable.

He was discharged as recovered on May 26, 1920.

His wife reports that he is his old self again since his discharge, but he has not taken any hormotone, as his wife did not think there was any necessity to continue it.

Case III.—E.S., aged 35, was admitted on July 7, 1916. On admission he was very depressed and would not speak. He understood what was said to him, but would only nod and shake his head in answer to questions. He did not actively resist examination, but was inclined to negativism. He took his food well and was clean in his habits. He remained in this negativistic state, rarely speaking, apparently not taking much interest in his surroundings; when he spoke he only spoke in a whisper and said: "It's awful."

On May 25, 1920, he was put on hormotone and about four months later he seemed somewhat brighter and was eating better. In January of this year he began to speak freely to his brother and initiated conversation, which he had not previously done since admission. About a month later he spoke freely to me in reply to questions and in reply to a question as to how he was said: "Not bad." Recently he has been reading the papers and entered into discussion with other patients in the ward. He is now doing ward work every day and looks as if he would soon be fit for discharge.[1]

Case IV.—J.P., aged 45, was admitted on November 19, 1919. A case of acute melancholia. The medical certificates set forth that he thought that he was being chased by blacks and others. He ran away into the bush, thinking he was being pursued. With regard to his physical condition, there was nothing to note.

On admission he had hallucinations of sight; he said that he saw blacks and others chasing him and that he galloped his horse for two miles until the horse became exhausted, that he was going to drown himself, because if these people got him, they were going to torture him, that the reason that he was chased was because there was an enmity between him and one of his pursuers. He was very depressed and miserable and he slept badly. Later he thought that two years previously he had been poisoned by a woman and that the poison was now going through his system.

On May 7, 1920, he was still very worried and in a general state of unhappiness; he felt at times that he would like to destroy himself by stabbing himself or taking poison or jumping off something. He still retained his delusions in regard to the poisoning.

On June 1, 1920, he was put on hormotone and on September 20, 1920, he was much brighter and working well in the ward. He said he did not now feel worried and had no thoughts of suicide. At this time he was detached and worked on the farm for about two months. At the end of this time he was discharged as recovered.

Case V.—J.J.Q., aged 11 years, was admitted on June 28, 1916. A case of sporadic cretinism. On admission his certificate set forth that he would not answer questions and could only speak in monosyllables; he was unable to distinguish between "yes" and "no"; he could scarcely walk; he was wet and dirty in his habits; he was originally a hydrocephalic. On physical examination he presented all the symptoms of cretinism. His forehead was overhanging and wrinkled, his eyes sunken, bridge of nose flat, lower lip protruding, hair coarse and his scalp was covered with scales of epidermis. His skin was thick and coarse and of a dusky yellow colour; his abdomen was prominent and umbilicus projecting. His back showed a deep furrow over the spine. There was a large, puffy swelling round his neck, like a collar, except at the centre, in front and behind. Mentally he was dull, stupid and listless. He did not speak, smile or cry, but lay quietly in bed. At first he was put on thyreoid extract, but did not make very much headway. About two months after admission he was put on hormotone and he then began to improve mentally and physically.

On April 22, 1917, he spoke more distinctly, ran about and played and showed considerable interest in his surroundings. He looked forward eagerly to picture shows.

On March 3, 1919, hormotone was unobtainable. He was therefore put on thyreoid extract, when he deteriorated mentally and physically; he became very dull and the collar of fat returned. Later on, when hormotone was procurable, he again made considerable improvement, both mentally and physically. Recently he has been put on thyreoid and again became dull and the teacher noticed that he would not play with toys that required any mental effort. His thyreoid gland also enlarged. Now he is on hormotone. At the present time his mental age is about five years.

This case is a very peculiar one, inasmuch as, according to our accepted knowledge, he should improve on thyreoid, whereas this was not the case; he only improved under hormotone.

In the following case hormotone was given, but the patient deteriorated mentally under that line of treatment.

Case VI.—E.H.B., aged 4½ years, was admitted on October 9, 1915. The certificate set forth that she was an imbecilic cretin, unable to walk or talk. She has been under thyreoid treatment for some considerable time with considerable benefit; but owing to bad seasons her mother was unable to continue it.

On admission her weight was 12.25 kilograms. She was unable to walk, stand or talk and was accustomed to being fed with a feeding bottle. Her hair was coarse and inclined to grow down her forehead; her head was square and her eyebrows were overhanging. Her nose was flat and her tongue protruding. There was a collar of fat on both sides of the neck. The abdomen was protruding and umbilicus prominent. Her hands and feet were short and broad. On admission she was unable to speak, was dull and cried immediately she was touched by strangers. She was put on thyreoid extract and a month later she took notice of playthings, laughed and smiled. A year after admission she made some attempts to speak and walked better. Her weight was 14.5 kilograms. She now talks a little and asks questions. Her mental age is about four years.

Pineal Gland.

Pineal is generally regarded as being depressant in grown-up people. For this reason it was prescribed in the following two cases of acute mania with somewhat startling results, as, in place of acting as a depressant, it had the very opposite effect. I intend to try this treatment on some cases of melancholia.

Case VII.—W.F., aged 53 years, was admitted on March 26, 1919, suffering from senile acute mania. On admission he was incoherent in speech; his memory was defective. At times he sang and whistled and was noisy at night. He thought that he could send wireless messages to England by tapping the bed. He had no idea of time or place. He remained in this acute maniacal state until August 18, 1919, when he was put on pineal gland, one tablet three times a day, each tablet corresponding to 0.03 grm. of the fresh gland. In a few days he was more excited than he had been previously, becoming quite unmanageable. Our supplies of pineal gland became exhausted at the end of about a month and so the treatment was discontinued, when he settled down to his former state.

On February 18, 1920, a fresh supply of pineal gland was obtained. The treatment was restarted, when he again became quite unmanageable and most restless than previously. At the end of a fortnight this treatment was stopped.

On May 25, 1920, he settled down and worked on the farm and was discharged on November 1, 1920, as recovered.

I do not in any way attribute this patient's recovery to the pineal gland treatment, but simply quote the case as showing the excitant action from this gland.

Case VIII.—G.A.M., aged 53 years, was admitted on October 11, 1919, suffering from senile acute mania. On admission he was restless, talkative, incoherent and would not stay in bed. He was exalted and continually talking in a

[1] The patient answered questions freely at the meeting.

loud voice and in an extravagant manner. He remained in this state until September 27, 1920, when he was put on pineal gland. He was appreciably more restless. He decorated himself with grass, which he had not previously done, and hoarded rubbish. This was continued for about a month, when he was taken off this treatment.

On January 7, 1921. he was again put on pineal gland, three tablets a day, when he again become more restless and almost unmanageable. This treatment was discontinued.

These two cases tend to show that pineal gland substance excites the cerebrum and on this account I intend to try it in cases of senile melancholia.

These cases are not the only ones treated by means of the ductless glands. Not all the cases have been successful; neither are all the successes included. For example, no improvement was shown by two cases of senile acute melancholia and some old cases of *dementia præcox* showed no improvement whatever.

This line of treatment was considerably interfered with during the war period, as during portion of that time supplies were unobtainable. At the same time, it seems to have opened up a new field in the treatment of mental diseases, which I hope others will assist in investigating.

Reviews.

VACCINATION IN THE TROPICS.

"Vaccination in the Tropics," by W. G. King, C.I.E., is a small volume[1] written by an eminently practical individual. It ought to be of immense usefulness to those engaged in the making of vaccine lymph.

On the literary side the book is rather weak. The author shows a fondness for the use of the long sentence, although he has not by any means acquired dexterity in its use. His syntax in certain parts of the book is very bad; this is aptly illustrated, for example, on page 26: "This is far below yields in temperate climates with European breeds." On page 28: "Once introduced into an institute, its eradication may become a difficult matter with the celerity desirable." And on page 64: "As a result of continued transfers from rabbit to rabbit of the strain."

Dealing in detail with the scope of the book, we find in Section I. descriptions of the different types of small-pox that have been observed, the mortality rates associated with these different types, the variations in mortality in families and races and also the differentiation of the mild type of small-pox from varicella.

In this section a reference is given to the work of Force and Beckwith, who showed that an intradermal inoculation into the sensitized rabbit of the contents of a vesicle in a doubtful case, gives a reaction if the case is one of mild small-pox, but none if it is varicella.

A short sketch of the work of the King Vaccine Laboratory is also given. It is shown that, owing to systematic vaccination, 572,000 odd lives were saved in the decade 1892-1902, at the small cost of 2,410,000 rupees. It is estimated that the expense that would have been entailed by the illness obviated in this way would have amounted to no less than 32,232,000 rupees, although no consideration is included in this account for the actual value of the lives that would have been lost. The cost is computed on the cost of food for the sufferers during illness, the cost of funeral and funeral ceremonies and the loss of wages. The actual saving was evidently much greater. Had such a number of lives been saved by the activity of our trans-Pacific cousins, we cannot but think that it would have been very much more widely known.

A very interesting section of the book is that dealing with the history of inoculation. It is shown that the Chinese inoculated by blowing powdered small-pox scabs into the nostrils and that inoculation was practised in India before the method was borrowed from the Turks by the people of western Europe.

Personal experiences collected by the writer, dealing with the protection conferred by natural small-pox, inoculation small-pox and vaccination against vaccinia are of great interest, since they show that neither natural small-pox nor inoculation small-pox gives a protection which is by any means absolute; indeed, the protection does not seriously differ from that given by vaccination.

The value of vaccination, in its protective power and its freedom from risk, is dealt with. The statistics that are quoted in this section, are not drawn to any great extent from the tropics, but rather from European sources.

A large amount of information is given about the origin of the vaccine virus and the best conditions under which it can be produced by passing small-pox virus through bovines.

The technique of the vaccination operation in human beings and in bovines, the preservation and carriage of lymph in the tropics, the selection of a site for a vaccination institute, with a discussion of the effects of the meteorological conditions as they affect lymph production, are set out in all practical detail.

In reference to the preservation of lymph, much information is given as to the relative keeping qualities of glycerinized and lanolinized lymph, from which there can be no doubt that the lanolinized lymph is very much more suitable for tropical use. This seems to bear on small-pox vaccination in Australia, where the vaccine lymph is supplied from a central institute in the southern part of the continent. This institute is a three weeks' journey from some of the remote districts, so that it is extremely likely that the lymph will become impotent if any failure in the cool storage arrangements occurs during transit. This is a matter which should be considered very carefully by those in charge of the Commonwealth Serum Institute.

The duration of potency of vaccine lymph under conditions of tropical heat and local conditions of transport is discussed in detail and in an appendix a short account is given of Noguchi's method of making vaccine lymph in the testicles of rabbits. This section, however, is not very good, as the author himself has not employed the method.

We consider that this book should be in the hands of all those engaged in vaccine lymph production, either within or without the tropics.

[1] Vaccination in the Tropics, by W. G. King, C.I.E.: 1920. London: Tropical Diseases Bureau: Royal 8vo., pp. 64, illustrated. Price, 5s. net.

PRACTICAL NURSING.

"Theory and Practice of Nursing," by Sister M. A. Gullan, of Saint Thomas Hospital, London, should be of estimable value to young women undergoing training and also useful as a reference to those who have become nurses.[1] The book is well arranged, each chapter comprising a complete survey of the various subjects which a nurse must know. Interleaved at frequent intervals are blank leaves for additional notes and data, which should encourage the permanent recording of much which is learnt in the daily routine of the ward work and later forgotten.

From the comprehensive title of this book, the reader would expect to find adequate treatment of the subject of surgical nursing. A chapter on surgical bacteriology and methods of sterilization alone comprises what is strictly surgical. No guidance is given as to the dressing of wounds, no mention is made of the various complications of wounds. Nothing is said of post-operative nursing, other than that of general nursing.

The chapter on enemata is especially worthy of mention, being well arranged. The purpose of the various enemata commonly in use is clearly indicated. The nutrient enemata of milk, eggs, etc., are rightly set aside in favour of the more useful one of glucose in saline solution. We note with regret that the quinine enema finds no place in this otherwise complete chapter. The description of the normal pulse and its variations in disease is exceptionally good, as is that dealing with baths and sponging. The book closes with a few notes on gynæcology, which are to the point and not too expansive.

[1] Theory and Practice of Nursing, by M. A. Gullan: 1920. London: H. K. Lewis & Co., Ltd.: Demy 8vo., pp. 214. Price, 10s. 6d. net.

Naval and Military.

APPOINTMENTS.

The following appointments, promotions, etc., have been published in the *Commonwealth of Australia Gazette*, No. 38, of April 28, 1921:

Permanent Naval Forces of the Commonwealth (Sea-going Forces).

Fixing Salary of an Officer—

The salary of Surgeon-Commander Edward Thomas Philip Eames, R.N., Director of Naval Medical Services, to be at the rate of £1,000 per annum, inclusive of all allowances except travelling; to date from 1st July, 1920.

Transfer to the Retired List—

Surgeon Lieutenant-Commander Jack Rupert Law Willis is transferred to the Retired List at his own request. Dated 18th February, 1921.

Australian Imperial Force.

To be Captain—

Captain W. Smellie, Australian Army Medical Corps, 11th September, 1916.

Appointments Terminated.

Second Military District.

Captain P. G. Crago, 13th March, 1920.

Third Military District.

The notification respecting the appointment of Austin Mahon to be Captain, Army Medical Corps, which appeared in Executive Minute No. 436/1916, promulgated in *Commonwealth of Australia Gazette*, No. 56, dated 11th May, 1916, is cancelled.

Australian Military Forces.

First Military District.

Australian Army Medical Corps—

Captain (provisional) J. H. Hornbrook to be transferred to the Reserve of Officers, Second Military District, and to be Captain, 30th March, 1921.

Captain J. Hardie, M.C., to be transferred to the Reserve of Officers and to be Major, 30th March, 1921.

Reserve of Officers—

The temporary rank of Lieutenant-Colonel granted to Major (Honorary Lieutenant-Colonel) H. H. B. Follitt is terminated, 30th September, 1920.

Captain (Honorary Major) A. V. Meehan is transferred from the Australian Army Medical Corps, Second Military District, and to be Major, 31st March, 1921.

Second Military District.

Australian Army Medical Corps—

Captain A. L. Kerr is granted the temporary rank and pay of Major whilst acting as Senior Medical Officer, Citizen Force Camps, Liverpool, New South Wales, 29th March, 1921.

Major K. S. Parker, M.C., is appointed from the Reserve of Officers and to be Captain, with corps seniority as from date of transfer, 16th March, 1921.

Major (Honorary Lieutenant-Colonel) H. R. G. Poate is transferred to the Reserve of Officers, and to be Lieutenant-Colonel, 31st March, 1921.

Captain (Honorary Major) R. I. Furber, D.S.O., is transferred to the Reserve of Officers, and to be Major, 31st March, 1921.

Captains K. R. W. George, and T. A. Grieves are transferred to the Reserve of Officers, 31st March, 1921.

The resignation of Captain N. P. Boulton of his commission is accepted, 31st March, 1921.

The resignations of Captains W. G. Shellshear, G. A. Buchanan, and J. E. V. Barling, of their provisional appointments are accepted, 31st March, 1921.

Captain (Honorary Major) A. V. Meehan is transferred to the Reserve of Officers, First Military District, and to be Major, 31st March, 1921.

The temporary rank of Lieutenant-Colonel granted to Captain (Honorary Major) A. V. Meehan is terminated, 30th March, 1921.

Reserve of Officers—

Colonel T. H. Fiaschi, D.S.O., V.D., is placed on the Retired List with the honorary rank of Brigadier-General, and with permission to retain such rank and wear the prescribed uniform, 1st January, 1921.

Captain (provisional) J. H. Hornbrook to be transferred from the Australian Army Medical Corps, First Military District, and to be Captain, 30th March, 1921.

The temporary rank of Lieutenant-Colonel granted to Honorary Major R. B. Wade is terminated, 1st March, 1920.

The temporary rank of Major granted to the undermentioned officers is terminated from the dates shown against their respective names: Captains C. G. Allen, 28th June, 1920; T. G. Allen, 29th December, 1920; B. M. Beith, 6th October, 1920; C. R. Hodgson, 1st August, 1920; Honorary Captains H. S. Marsh, 28th February, 1919; C. W. Whiting, M.C., 19th June, 1919; W. Blaxland, 24th March, 1921; J. C. Booth, 1st June, 1920.

Third Military District.

Australian Army Medical Corps—

Major H. B. Lee, D.S.O., M.C., is appointed from the Reserve of Officers with corps seniority as from date of transfer, 2nd March, 1921.

Captain P. J. Campbell is transferred to the Reserve of Officers, 13th January, 1921.

The resignation of Captain A. Lyons of his provisional appointment is accepted, 2nd March, 1921.

To be Captains (provisionally)—

Charles William Adey and James Amess Troup, 26th February, 1921, and 30th March, 1921, respectively.

Captain S. Crawcour to be appointed from the Reserve of Officers, with corps seniority as from date of transfer, 30th March, 1921.

Captain H. A. Deravin to be transferred to the Unattached List, 30th March, 1921.

Captain M. D. Silberberg to be transferred to the Reserve of Officers, 25th February, 1921.

Major (Honorary Lieutenant-Colonel) J. C. Morton and Captain (Honorary Lieutenant-Colonel) E. B. Allan to be transferred to the Reserve of Officers and to be Lieutenants-Colonels, 30th March, 1921.

Reserve of Officers—

Captain H. Fleming Dunstan, Reserve of Officers, Fourth Military District, is granted the temporary rank and pay of Major whilst employed at No. 11 Australian General Hospital, 21st March, 1921.

The temporary rank of Major granted to Honorary Captain W. H. Steel is terminated, 5th February, 1921.

Australian Army Medical Corps Reserve—

The temporary appointments of Honorary Captains D. J. Thomas and A. W. Shugg are terminated, 29th October, 1919.

Fourth Military District.

Australian Army Medical Corps—

The honorary rank of Major granted to Captain P. W. Rice is terminated, 1st April, 1921.

Reserve of Officers—

The temporary rank of Major, granted to Honorary Captain G. Brown is terminated, 1st April, 1921.

Fifth Military District.

Australian Army Medical Corps—

Colonel D. M. McWhae, C.M.G., C.B.E., to be transferred to the Reserve of Officers, 1st March, 1921.

Captain (provisional) S. Mathews to be transferred to the Reserve of Officers and to be Honorary Captain, 1st March, 1921.

Captain (temporary) E. C. East to be transferred to the Reserve of Officers and to be Captain, 30th March, 1921.

The Medical Journal of Australia.

SATURDAY, MAY 14, 1921.

Corporate Membership of the Association.

The report of the Council of the British Medical Association on "The Question of Steps to be Taken Whereby the Association may Become in Part a Federation," as published in the Supplement of the *British Medical Journal*, of March 5, 1921, demands very careful and detailed study by all members of the Association in Australia. That the Council has not appreciated the difficulties which beset the Branch in the Commonwealth, is both apparent and regrettable. The report deals with the proposals for giving effect to the demand for admission to the membership of the Association of three distinct classes of bodies. In the first place there are the bodies, at present Branches of the Association, which desire to retain all the privileges of membership and at the same time power to carry out all the objects of the British Medical Association, as set forth in the Memorandum of Association. To enable these Branches to gain a sufficient degree of autonomy to carry out all the functions of the parent Association, it is essential for them to become incorporated under the *Companies Acts* of the States, Dominions or Provinces in which the areas of the Branches are situated. The second class of bodies comprises outside medical societies, whose members are not necessarily members of the British Medical Association, and whose objects are not co-terminous with those of the Association. The third class includes societies with non-medical members. These societies would embrace the allied sciences and professions. We may dismiss the questions involved in the consideration of the second and third classes of members with a few words. The admission of outside medical bodies and of non-medical associations involves a new principle. Before the Association is prepared to accept this principle, the individual Divisions and Branches have to register a decisive mandate. It is as well to remember that the total membership of the British Medical Association is approximately 22,000, of which 3,000 are attached to the Australian Branches. It is very rare for more than one-half of the members to be represented at a Representative Meeting. This means that if a "card vote" were taken on this matter of vital concern to the overseas members, the unanimous wishes of the members of the Association in Australasia would probably determine the issue.

The admission of incorporated bodies, corresponding to the Branches of the Association, does not involve any new principle. In effect the problem resolves itself into the creation of machinery necessary to permit certain more or less isolated Branches of the Association to do all those things which the parent Association can do without involving the parent Association in any financial or other responsibility.

Before considering the proposals of the Council, it may be of importance if reference be made to the Memorandum of the Association. The Association exists for the promotion of medical and the allied sciences and the maintenance of the honour and interests of the medical profession and may achieve these objects by holding meetings, by publishing journals, transactions and the like, by granting sums of money for the promotion of the medical and the allied sciences and by doing such other lawful things as are incidental or conducive to the attainment of the objects. It is a matter of history that the chief reasons actuating the Association to apply for a Royal Charter in 1905-1907 were its desire to promote the candidature of any member of the Association for Parliament, to undertake the defence of individuals in civil or criminal legal proceedings involving the honour or interests of the medical profession, to provide facilities for the sale or transfer of practices, to organize and manage provident or benevolent funds and to undertake and carry out the execution of trusts. It was found that the Association could not obtain power to carry out these things under the *Companies Act*. Unfortunately the application for a Charter failed and the Association still has no power to perform the acts just mentioned. The Branches, as integral parts of the Association, have no power to sue or to be sued; they cannot hold property, publish a journal nor perform

any of those things which a responsible, autonomous body would require to carry out for the purpose of attaining the objects of the Association. The Branches of the Association in Australia have to provide machinery in every respect analogous to that of the governing body of the British Medical Association. Many of the problems confronting the medical profession in the Commonwealth are peculiar to Australia and therefore it is eminently desirable that the Branches should possess a degree of freedom of action consistent with the constitution of the Association. It must, furthermore, be remembered that the Branches in Australia work under the Memorandum of Association of the parent Association and have no desire to go outside this legal restriction.

The Council proposes that the Branches on becoming incorporated for the purpose of obtaining exactly the same powers as it itself possesses, shall terminate their membership of the Association and then apply to the Representative Body in which they would have no voice, for admission on terms to be prescribed by that body. The Council does not offer any preferential treatment to these Branches as compared with an outside medical body or a non-medical body. It is prepared to recommend the Representative Body to restrict the privileges of membership of the Australian Branches by denying them the power of registering a vote at the Representative Meetings. On the other hand the Council would leave it to the Representative Body to fix the amount of subscription by way of capitation or otherwise. In other words the Branches would be disfranchised and at the same time would be required to pay to the parent Association for the privilege of affiliation a subscription for each member to be fixed by the Representative Body.

In its report the Council introduces a principle involving the maintenance of a close relationship between purely medical bodies and the Association and the establishment of a looser bond between bodies not purely medical and the Association. The intention is admirable, but the amendments to the Articles and By-laws have been drawn up in such a manner that no differentiation is rendered mandatory on the Representative Body. The machinery is so elastic that the conditions of membership of an incorporated Branch would be left to the Representative Body to determine after the Branch had severed its connexion with the parent Association. There is no word devoted to the interchangeability of membership of the incorporated body and the Association. There is, on the contrary, an indication in the text of the report of the Council's opinion that the individual members of an affiliated body would not be able to enjoy full privileges of membership. In paragraph 8, it is clearly set forth that the right to vote in a referendum is not conceded, because in the event of a large body becoming affiliated, the individual vote might control the situation. We would urge that this privilege should not be extended to an outside body seeking and obtaining affiliation. The relations of a former Branch becoming a corporate member to the Association, however, are of an entirely different nature. The parent Association stands to lose nothing by granting full privileges to an overseas Branch desiring wider autonomy than can be secured as a Branch. By offering to it an emasculated membership, the Council appears to misunderstand the position of the Branches in Australia and to be unaware of the yeoman service of the Branch Councils during the past quarter of a century. We have a right to expect a better recognition of the organizations which have succeeded in attracting approximately 90% of the available medical practitioners to the fold. Dr. R. H. Todd, the delegate of the Australian Branches, will, we feel convinced, argue the case of these Branches in a powerful manner and induce the Council to adopt a more generous attitude toward them.

THE PRINCE OF WALES'S APPEAL FOR THE BOY SCOUTS.

In our issue of March 12, 1921, we published a note, asking our readers to give their support to the appeal which His Royal Highness the Prince of Wales, as Chief Scout for Wales, is making on behalf of the Boy Scouts Association. The sum of £200,000 is required to enable the movement to be conducted on a proper basis throughout the British Empire. We learn that £55,000 has already been collected for this purpose. In addition the National Service League has determined to place its assets, estimated at £10,000, at the disposal of the fund. Strenuous efforts are being made to secure the remaining £135,000 from the citizens of the Empire. It is scarcely necessary to point out in this place how valuable this movement is. The Boy Scouts Association stands for loyalty, patriotic service and preparedness. The training benefits the individual boy and fosters in the nation

a spirit of British sentiment and of British self-denial and pluck. The genius of Sir Robert Baden Powell is recognized on all sides and deserves the support of everyone.

In response to the request of the Prince of Wales's Boy Scout Development Fund *The Medical Journal of Australia* has undertaken to open a "Shilling Fund." Contributions of one shilling or more may be sent to the Editor for the Prince of Wales's Fund. It is hoped that the medical practitioners of the Commonwealth of Australia will respond readily to this appeal to send a substantial contribution to His Royal Highness through the agency of their own journal.

LINEAR DIVISION OF THE PYLORIC SPHINCTER.

The rapid development of surgery in the last half century is a triumph for the ingenuity and daring of the modern mind. Operations which seemed *a priori* the devices of madmen, have been added to the system of surgery and have been proved rational and invaluable. Those who first resected portion of the stomach for the cure of cancer, who first removed the spleen in the treatment of splenomegaly and who, greatly daring, first replaced the pedicle of an ovarian cyst without clamps, were men who by wise temerity added greatly to the sum of surgical knowledge. The great men of surgery have helped to free us from the shackles of our own fallibility. What seemed to us wise procedures they have proved wrong and what seemed to us hare-brained devices we have now humbly admitted into our daily practice.

When Rammstedt first proposed to treat the congenital hypertrophic pyloric stenosis of children by a simple division of the pyloric sphincter without suture, he aroused considerable opposition. The proposal seemed at variance with the accepted principles of gastro-intestinal surgery. It was feared that the contents of the stomach, separated from the peritoneal cavity by a mere sheet of mucous membrane which might itself have been punctured with the scalpel, would under pressure from the movements of peristalsis rupture into the abdominal cavity. And yet experience showed that Rammstedt was right and his opponents were wrong. Simple linear section of the pylorus not only freed the child from the distressing symptoms of pyloric obstruction and restored the creases of fat to his limbs and the chubbiness to his cheeks, but it was a permanent cure of the disease from which the little fellow suffered no more. So successful has this operation been that Dr. Charles A. Pannett,[1] of London, has considered the question of its applicability to the treatment of other disorders of the stomach. He set out to discover the effect on the normal stomach of linear division of the sphincteric muscle of the pylorus and he used one male and two female cats as the subjects of his experiments. The animals were trained to remain quiet while X-ray photographs were taken of meals of boiled fish mixed with barium sulphate which had been given after an all-night fast. The two females responded well to the training, but the more spirited male cat refused to be subdued. Several skiagrams were obtained, which demonstrated the passage of the meal from the stomach into the long intestinal tract. The cats were then operated on and the pyloric sphincter was incised for about 1.25 cm. on its anterior aspect. The mucosa was left intact and in order to support it a small curtain of omentum was sutured to the musculature surrounding the incision. The abdomen was closed with catgut and the wounds healed by first intention. The three animals were killed 7, 14 and 18 weeks respectively after operation, but in the meanwhile other experimental meals were given. It was found that the food passed in much greater quantity and with much greater rapidity into the duodenum and jejunum. *Post mortem* the cat killed 7 weeks after operation showed a simple linear scar at the site of incision and microscopical examination proved that a very thin layer of muscle had not been severed, although the wound had gaped widely at operation. The second cat had a shallow bulging of the mucosa with no covering of muscle, while the third cat, killed 18 weeks after operation, showed a muscular scar without diverticulum.

Dr. Pannett suggests that the operation may be applied to man in three morbid conditions of the stomach, *viz.*, cicatricial stricture resulting from pyloric ulcer, the pylorospasm which is commonly associated with ulcer of the body of the stomach, and hyperchlorhydria when associated with distressing symptoms. The operation has already been attempted for the relief of the first condition, but the after-results are not yet available. Dr. Pannett's investigations are very suggestive, but they are inconclusive. The results obtained from three animals are too few on which to base a definite judgement and the different modes of healing of the pyloric wound show that different factors operated in each case. It would have been an even more interesting experiment if the veil of omentum had not been sutured over the incision. It is possible that the movements of the omentum dragged the edges of the wound together in two instances and apart in the other. Simple incision without the formation of an omental curtain would probably have led to more uniform results and it would then have been determined whether the tone of the musculature was sufficient to prevent leakage of the gastric contents. Dr. Pannett's experiments would appear, however, to prove that incision of the pyloric sphincter allows the more easy passage of food from the stomach and should, therefore, be of value in the treatment of pyloric obstruction.

[1] *British Journal of Surgery*, January, 1921.

PROFESSOR HUNTER'S ARTICLE ON TWIN TUBAL PREGNANCY.

We regret to record that the illustration Figure II. in Professor Hunter's article on twin tubal pregnancy which appeared in last week's issue, has been printed upside-down in an unknown number of copies. The block for this illustration was reversed by our printers without authority from or reference to us during the course of the machining of the journal. The smaller chorionic vesicle (H_{234}) should be to the left of the picture.

We have been asked to state that St. Luke's Hospital, Darlinghurst, will be re-opened on May 18, 1921, by His Excellency the Governor of New South Wales. The hospital contains 30 beds, five of which will be available at a fee of £2 2s. a week, the remainder at ordinary private hospital rates.

Abstracts from Current Medical Literature.

DERMATOLOGY.

(169) Anaphylactoid Dermatitis.

That the skin of susceptible persons may be sensitized by specific substances existing in the epidermis of certain animals and react later to direct contact with those substances is the view of Arthur J. Markley (*Archiv. Dermatol. and Syphilol.*, December, 1920). A married woman, aged 39 years, was admitted to hospital suffering from a skin eruption of six months' duration. The rash was erythematous and papular and involved the whole of the face, neck and chest and the anterior aspects of the forearms. The eyes were suffused and weeping and the patient was subjected to great discomfort by the intense itching, which was chiefly nocturnal. As the hair was dry and the scalp scaly a diagnosis of seborrhœic dermatitis was made, but vigorous treatment for this condition failed to relieve the symptoms. Under general treatment which included dental attention and special dieting, and after removal of the *appendix vermiformis*, the affection was considerably relieved, but it returned later in a more intense form and the patient was in despair. Then she suddenly remembered that the skin lesions always became worse after she cleaned out the pen of a pet guinea-pig and allowed it to run about over her shoulders. The animal was at once dismissed and the eruption entirely disappeared. Eight months have elapsed and there has been no recurrence. Tests were carried out to prove the specificity of the reaction by the skin to the irritant. Patches of hair from a guinea-pig were bound to the side of the patient's neck for four hours. Within 24 hours local vesication and erythema appeared and spread to those areas of the skin involved in the original eruption. The lesions on repeated experimentations always failed to appear on other parts of the body. Control tests on another person and tests made with the hair of other animals failed to yield a reaction. The relation of these observations to the phenomena of anaphylaxis is unknown. As the skin may be sensitized by definitely non-protein substances, it is often denied that these cutaneous reactions are related to the anaphylactic state. They may be merely responses of the skin to substances of the nature of toxins rather than antigen-antibody reactions, but as the reactions are specific the author has felt justified in using the term "anaphylactoid."

(170) Pseudo-Icteric Xanthosis.

F. Parkes Weber has written in the *British Journal of Dermotology and Syphilis*, March, 1921, an account of a diffuse pseudo-icterus or xanthosis of the skin, usually found in certain young patients suffering from *diabetes mellitus*. This condition frequently simulates true jaundice which is a colouration of the skin and sclerotic membranes of the eyes with bilirubin. During the recent war malingerers were detected who swallowed as much as one gramme of picric acid in order to produce a yellowness of the skin, *sclera*, blood-serum and cerebro-spinal fluid, thereby hoping to evade military service. The urine contained picric acid and at a later stage bilirubin in those instances in which a true jaundice was added to the artificial. In December, 1919, A. F. Hess and V. C. Meyers reported another form of pseudo-icterus, most noticeable on the palms of the hands and soles of the feet, not involving the sclerotic membranes and due to excessive consumption of carrots, spinach and other substances containing a large amount of carotin. The most commonly known form of pseudo-icteric yellowness or xanthosis of the skin, however, occurs in association with *diabetes mellitus*. The hands and feet are affected markedly, the eyes slightly, if at all. The condition is said to be due to a lutein-like lipoid substance in the blood. It is possibly related to *diabète bronzé*, as suggested in 1904 by von Noorden. As a rule there is no bilirubin in the urine, but there is a yellow colouration of the urine and of the blood-serum (xanthæmia). The author records a case of congenital xanthosis, involving the eyes and skin; in an otherwise healthy man. He has been yellow since birth, is now 54 years of age, has always been healthy and has four healthy normal children. There is no splenomegaly and no enlargement of the liver or lymphatic glands. The urine is clear, pale yellow, and free of albumin, sugar or bilirubin, and contains no excess of urobilin, urobilinogen or indican. A blood count showed 6,400,000 red cells in each cubic millimetre and 5,710 leucocytes, while the hæmoglobin value was 105%. There was no apparent fragility of the red cells. The blood serum was deeply coloured but was apparently free of bilirubin, urobilin and urobilinogen.

(171) The Diagnosis of Diseases of the Lungs.

G. N. Norris (*New York Medical Journal*, November 27, 1920) has described the X-ray examination of lesions of the lungs. Clinically it is possible to recognize pleural adhesions in some cases but not in all, but an X-ray examination will at once demonstrate the lesion. Moreover, an effusion of fluid can be discovered readily by radiography but it can rarely be definitely diagnosed clinically until a considerable collection is present. Localized collections of fluid and localized pneumothorax can only be diagnosed by X-ray examination while interlobar empyema often baffles the clinician. Abscess and foreign bodies in the lungs are both easily recognizable radiographically. It has been proved by X-ray examination that lobar pneumonia commences centrally and extends to the periphery and this fact explains the frequent absence of physical signs in cases of early pneumonia. The diagnosis of delayed resolution is difficult by physical signs but is possible radiographically. Extensive tuberculous lesions are frequently revealed by radiograms of the thorax in which physical signs were few or absent, but the author considers the stethoscope superior to the radiogram when it is necessary to determine the activity or quiescence of the pulmonary involvement.

(172) Treatment of Enlarged Tonsils with X-Rays.

A report by Murphy, Witherbee, Craig, Hussey and Sturm on the induction of atrophy of the tonsils by means of Röntgen rays has appeared in the *Journal of the American Medical Association*, January 22, 1921. The authors have had great success in the treatment of hyperthophied tonsils by this method. Early in the practice of radiography it was noted that lymphoid tissue was easily destroyed, and by experimental work the authors showed that it was possible to destroy practically all the lymphoid tissue in the body by carefully applied doses of the X-rays. The dose employed was five milliampères of current with a 20 cm. spark-gap, at 25 cm. distance from the skin. The time varied from three to seven minutes and a three mm. aluminium filter was used. The rays were directed through the tonsil from behind the angle of the jaw, the remainder of the head and face being protected by lead. Three or four sittings are necessary at intervals of 14 days. Distinct shrinkage of the tonsils follows the treatment and the surfaces become smooth and pale. Adenoids are unaffected by the treatment.

(173) Cardiospasm.

In P. F. Butler's opinion (*Amer. Journ. Röntgenology*, October, 1920) cardiospasm is usually secondary to some abnormal abdominal condition, *e.g.*, gall-bladder disease, duodenal ulcer, appendicitis or even pelvic disease. Two of his patients were cured after removal of a diseased appendix in each case. The spasm is at first mild, but soon increases in intensity and the cardiac sphincter becomes hypertrophied and the lower œsophageal musculature thickens. The chronic obstruction causes a dilatation of the œsophagus above the stricture and this dilatation may become enormous and capable of holding several litres of fluid. The clinical features are absence of pain, difficulty in swallowing (especially in the case of fluids), an early sense of fullness after food or drink, copious regurgitation, loss of weight and constipation due to the lack of fluids. Cardiospasm is a condition of adult life and is commoner in males. The vomitus consists of undigested food and contains no blood and no gastric elements. The radiographic picture is typical, the shadow of the huge dilatation of the œsophagus with its smooth lower end being quite unlike dilatation.

BIOLOGICAL CHEMISTRY.

(174) Basal Metabolism and Pulse-Rate in Hyperthyreoidism.

C. C. Sturgis and E. H. Tompkins have studied the basal metabolism in cases of hyperthyreoidism and compared it with the pulse rate (*Archives of Internal Medicine*, October, 1920). The metabolism determinations were made on patients after they had been fasting for twelve to fourteen hours and at a time when, as the result of rest, the pulse had reached its lowest rate. The expired air was collected in a spirometer and analysed in a Haldane gas analysis apparatus. The heat production in calories per square metre per hour was then computed and compared with the normal standards of Du Bois. The results were expressed as percentages of the normal. During the determinations the pulse was counted six to nine times and the average of these counts taken. The upper limit of normal metabolism has been placed at +15%. The study shows that there is a fairly constant relation between the pulse rate and the basal metabolism in a large percentage of cases. In a study of 496 determinations of the basal metabolism of 154 patients it was found that there was a tachycardia of 90 or more to the minute, associated with a basal metabolism of +15% or more in all but 16% of the cases. In 70 instances when the metabolism fell to normal, 78% of the patients had a simultaneous fall in pulse rate to below 90. Of 52 patients on whom a number of determinations of metabolism were made, the pulse rate as compared to the metabolism gave an accurate idea of the course of the disease in 85%. There is in general an interrelationship between the pulse rate and metabolism when a group of individuals is considered. An extreme degree of tachycardia suggests a greatly increased metabolism, while a slight tachycardia usually indicates a slight or moderate increase. The fact that a pulse rate after complete rest of less than 90 per minute is seldom and a rate of less than 80 is rarely associated with an increase in metabolism, is of practical importance in the recognition of the large group of nervous patients who have symptoms similar to those occurring in hyperthyreoidism.

(175) Fat in Diet.

T. B. Osborne and L. B. Mendel have investigated the importance of fats in the dietary (*Journal of Biological Chemistry*, December, 1920). The authors point out that much work has been done in an attempt to prove the importance of fat in the dietary, but proper attention has not always been given to the vitamine content of the fat and to the effect of absence of this factor. Several recent writers, particularly in Germany and Austria, have not emphasized adequately the distinction in the significance of fats as sources of energy and carriers of vitamine and of lipoids regarding the rôle of which information is incomplete. Osborne and Mendel fed rats on a diet very poor in fats, but containing the fat-soluble vitamine in dried alfalfa (lucerne). The largest daily intake of substances (? fat) extractable with ether for any animal of the series was 0.078 gramme. Nevertheless, the animals grew on the diet with vigour. Inasmuch as all the animals starting on the diet with a body weight of approximately 70 grammes quadrupled their weight within the usual time and appeared as well nourished as companion rats on diets containing liberal portions of butter, fat or lard, the conclusion is drawn that if true fats are essential for nutrition during growth, the minimum necessary must be exceedingly small.

(176) Blood Chemistry of Pernicious Anæmia.

A. O. Gettler and E. Lindeman made chemical examinations of the blood of eighty-seven patients suffering from pernicious anæmia (*Archives of Internal Medicine*, December, 1920). They found that the non-protein nitrogen, urea and creatinin values were in many instances somewhat higher than normal. In 48% of the cases the non-protein nitrogen was above the normal limit, in 18% the urea nitrogen was above normal, and in 42% the creatinin was above normal. They consider than the increase was due not to a permanent kidney lesion, but rather to the decreased amount of circulating blood. The uric acid was increased in 90% of the cases and in some instances the values were as high as 9 and 10 milligrammes (the normal figure is from 0.5 to 3.0 milligrammes). The amino-acid content was greatly increased, the increase being due to excessive destruction of serum protein. In most of the cases the blood sugar was abnormally high and the alkaline reserve was subnormal. These last findings show that in pernicious anæmia the power of oxidation within the cell is reduced to an abnormally low level. The serum proteins were greatly reduced, in some cases by as much as 40% to 50% of the amount in normal serum.

(177) Albuminuria and Pseudo-Albuminuria.

In the course of examinations of urine for the presence of albumin, substances of an albuminoid nature which can easily be confused with true albumin are sometimes found. These substances are serum albumin and serum globulin and the name "pseudo-albumin" has been given to them since they have little interest other than the errors to which they may give rise. J. Leclercq has studied these substances and gives tests for distinguishing them from true albumin and from one another (*Gazette des Praticiens*, October, 1920). Leclercq also describes as pseudo-albuminuria those conditions in which the urine contains albumin due to the presence of seminal or prostatic fluid. In these cases there is generally a genital, prostatic or vesical lesion of bacterial origin. Albuminuria of these types is intermittent and the author suggests that the albuminuria called "physiological" or "orthostatic" may be in reality a genital albuminuria. The so-called urinary mucin is not a true mucin, for it contains no carbohydrate in its molecule. This urinary mucin, pseudo-albumin or mucinoid substance as it is variously named is not coagulable by heat but by acids even in a cold medium. If a cloud appears in the urine when a few drops of acetic acid are added and this cloud is intensified when the acidified urine is heated, it may be assumed without doubt that the urine contains albumin. A syrupy solution of citric acid containing 100 grammes of citric acid and 75 grammes of water is recommended for use when testing for pseudo-albuminuria. Urine is floated on the surface of a few cubic centimetres of this solution in a test tube. If the urine contains pseudo-albumin a more or less intense cloudy zone will appear at the junction after a minute or two. If the urine contains only albumin there will be no precipitate nor cloudiness, even if there are five to eight grammes of albumin present in each litre. To Heller's test with nitric acid pseudo-albumin gives a cloud above the plane of separation of the two fluids, while true albumin gives a cloud at the line of junction. If trichlor-acetic acid gives no cloudiness when added to urine, it may be concluded that there is neither albumin nor pseudo-albumin present. If a cloud appears, Heller's test is done and controlled with the special reagent.

(178) Excretion of Indican and Phenols.

F. P. Underhill and G. E. Simpson have studied the effect of diet on the excretion of indican and phenols (*Journ. of Biol. Chemistry*, October, 1920). They have studied three normal men and a dog and they find that the excretion of both indican and phenols varies directly with the protein intake. In their smaller fluctuations the excretion of phenol and indican does not necessarily vary in the same direction. In most cases a large variation in indican excretion is accompanied by a variation in phenol excretion in the same direction. A high indican excretion by an individual does not necessarily mean a correspondingly high excretion of phenol by that individual. The effect of even mild constipation overshadows the effect of diet on the excretion of these substances, causing a large increase in the excretion of both indican and phenol. Those diets which promote the growth of putrefactive bacteria also promote indican and phenol excretion. Meat ingested in large quantities causes a marked increase in the excretion of the phenols and indican. Casein causes a moderate excretion of indican and the phenols. Gelatine, containing no tryptophane nucleus, causes cessation of indican excretion, with no change in the excretion of the phenols. On a diet containing large quantities of lactose the excretion of indican and the phenols was lower than when the diet contained a large amount of protein.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the Western Australian Branch was held at the Hospital for the Insane, Claremont, on March 20, 1921, Dr. A. T. White, C.M.G., V.D., the President, in the chair.

The Year's Work.

The President read the following account of the work of the Council during the preceding twelve months.

Before making my Presidential Address I will endeavour to cover the important work which has been done by the Association during the past 12 months, including the Council's Report.

Death of Members.

I must first of all express our deep regret at the great loss we have sustained by the death of Dr. Blackburne at Albany, who, in the prime of life, met a tragic death in the performance of his professional duties. I also regret to record the death of Dr. Samuel Macaulay, who was one of our oldest esteemed members. Letters of condolence were sent to the relatives of both of these late members.

Number of Members.

Since the outbreak of war, when our members were 126, they have increased until they number 154 at the end of the financial year.

New Members.

During the year the following new members were elected: Dr. Abernethy, Dr. Burns, Dr. Collins, Dr. Field-Martell, Dr. Horan, Dr. Pailthorpe, Dr. Phillips, Dr. C. J. Quinlan, Dr. C. Richards, Dr. Russell, Dr. Smith, Dr. Vivian and Dr. Wallace.

Transfers.

The following members were transferred from other Branches: Dr. Connell from Victoria, Dr. Dale from Birmingham Branch, Dr. Stott from Victoria, Dr. Rundle from Victoria, Dr. Stenning from London, Dr. O'Flynn from Queensland, Dr. Hislop from Victoria, Dr. Cass from Victoria and Dr. M. B. Johnson from Victoria, while Dr. Barrack was transferred to the New South Wales Branch and Dr. Pomroy to the South Australian Branch.

Resignation of Members.

I regret that during the year the following members resigned: Dr. Alfred Webster and Dr. Morgan Richards.

Meetings.

Nine general meetings were held during the year, seven at the Perth Public Hospital, one at the Hospital for Insane, Claremont and one at the Base Hospital, Fremantle. The average attendance of members at the meetings was 29, compared with 19 last year. In addition to these general meetings there was the annual dinner. Instead of holding the ordinary meeting in November it was resolved to hold an annual dinner. This proved a great success and was attended by 42 members. If this function is continued annually, it should have the effect of bringing members together. I would suggest it being held later in the year between Christmas and New Year, when country members could attend.

The Council has held ten meetings, with an average attendance of six.

The Ethical Committee met twice during the year with satisfactory results.

During the year interesting cases and specimens were shown by Drs. Stubbe, Trethowan, Randell, Bentley, Seed, Atkinson, Cantor, Holland, Anderson, T. Gill, F. McGregor, Martell, Juett, Dale, Hadley and Blackall.

Interesting papers were read during the year by Drs. Bentley, McWhae, Juett, T. Anderson and Barber.

Federal Committee.

During the year the constitution has been altered, which had the support of this Branch, to provide for the general expenses of the Federal Committee, including travelling and other personal expenses of members.

Re Further Powers Under the Constitution, etc..—This Branch supported the Federal Committee and agreed to pay this Branch's quota towards the expenses of a representative to England.

Drs. Seed and Hadley were re-appointed as this Branch's representatives on the Federal Committee.

Representative at the Annual Meeting.

Dr. Merryweather accepted the Council's invitation to represent this Branch in England and on his return to the State reported to the Council in November, 1920, the result of the meeting held at Cambridge on June 25, 1920, that there were 2,000 members present, four of whom represented the Australian Branches; namely, Drs. Pockley, Berry, Sprott and Merryweather. Dr. Merryweather was duly thanked by the Council for representing them in England and for his report.

Dr. F. H. Hadley was elected Branch representative on the Representative Body to be held at Newcastle-on-Tyne, England, in 1921.

Ethical Rules.

These having been carefully gone into by the Ethical Committee and the Council, were adopted by general meeting, printed and issued to all members.

Annual Subscription.

Owing to the annual subscription to the British Medical Association being raised, it was found necessary to increase the annual subscription to members of the Branch from £3 3s. to £4 4s.. In common with other Branches in Australia, a protest has been put up to London to reduce the subscription to the Australian members to its former amount of £1 5s.. I hope this will have beneficial results.

Incorporation of the Association.

During the year the incorporation has been brought up to date by the necessary lodging at the Supreme Court, revision of the rules and the appointment of trustees and seal holders. The present trustees and seal holders appointed during the year are Drs. Clement, Trethowan and Shearman.

Annual List of Members.

Attention having been called to the fact that decorations and orders of distinction were published in the list of New South Wales Branch members, it was resolved that orders of distinction be published in the list of members of this Branch.

Medical Congress.

The proposal to hold the next medical congress in Perth was considered during the year, but no definite action was taken and further consideration has been deferred.

The Council of this Branch supported the Queensland Branch's resolution to the Federal Committee that in the event of the next session of congress being held in Tasmania, no concession or entertainments should be received from the Tasmanian Government nor any representative of the Government take part in the congress.

Repatriation of Returned Soldiers.

The question of returned soldiers being treated in the Perth Public Hospital, was raised at the instance of Dr. Kenny. The scheme to be carried out was outlined by Dr. Barker. The result was that the Branch expressed strong opposition to honorary attendance on returned soldiers and urged that the care of these men should be entrusted to returned medical men, both internally and externally.

Medical Examinations under War Gratuity Board.

The Council of this Branch has supported the Federal Committee in accepting a uniform fee of 10s. 6d. for medical service under the Central War Gratuity Board.

Protection of Practices of Members on Active Service.

During the year the protection of practices of members who went on active service, was withdrawn.

War Patriotic Fund.

During the year the Committee of this Fund submitted a detailed revised scheme. This matter was carefully gone into by the Council, who received a deputation from the War Patriotic Fund Committee. As a result the general meeting adopted the recommendations of the Council and the revised scheme with modifications was approved of. This should prove beneficial to the dependants of soldiers. The scheme provides for the attendance of medical men at the rate of 4s. per consultation and 5s. per visit in the metropolitan area and increased fees in country districts. Those entitled to the benefits are the widows and dependants of soldiers who have died on active service, the wives and children of disabled soldiers and also the wives and children of soldiers who have returned, but whose income

including pension does not exceed £5 per week, provided they are approved of by the Committee of the War Patriotic Fund. Any case considered deserving by the War Patriotic Fund of the dependants of returned soldiers whose wages excluding pension is over £5 per week, have to be referred to the Council before being approved of as being entitled to benefits under this Fund.

Opticians Bill.

During the year the Opticians Bill was presented to Parliament and strenuous efforts were made to oppose the registration of opticians as sight testers. Although the Bill has not yet passed Parliament, very little interest or opposition was given by the public on this all important matter. The thanks of the Association are due to Dr. Saw for his good work in this connexion in Parliament and to Dr. Paton for assisting the Council.

Early Closing for Chemists' Shops.

The Branch was asked to send a representative to the Parliamentary Select Committee on the Bill. Dr. Holland was appointed and agreed to attend on behalf of the Branch.

Health Inspectors' Association.

During the year a congress was held by the Health Inspectors' Association and two delegates, Drs. Seed and Barber, were elected to attend on behalf of the Branch.

Conference on the Welfare of the Blind.

During the year a conference on the welfare of the blind was held, when Drs. J. Thompson and Claude Morlet represented the Branch as delegates.

Repeat Orders for Morphine.

This matter was brought before the Council by the Customs Department. The Council decided to circularize every medical practitioner in the State and urge that no prescriptions for morphine be issued without the inscription "no repeat." They have also asked for the Pharmaceutical Society and the Nurses' Association to confer on this matter.

Medical Fund Agreements.

During the year the Branch advised the doctors at Yarloop, Bruce Rock and Menzies in reference to medical fund agreement, which provided for a *per capita* payment and a wage limit.

Medical Fees.

During the year the question of medical fees was raised by Dr. Martell and was given careful consideration at several meetings, which eventually resulted in a resolution that the fees be raised 25%. The question of lodge fees was also considered and it was agreed to raise them to a minimum of 26s. per head and if this was not agreed to by the friendly societies, the matter was to be referred to the Council. Before approaching the friendly societies again with a definite scheme, the Council decided to obtain the support of the members throughout the State. The matter was given careful consideration and a circular was issued to 149 members. To date about 100 replies have been received, practically unanimously supporting the Council. About one dozen objections or suggestions have been received and these are receiving the careful consideration of the Council, and if necessary, the Council will again approach members.

Reduction in Subsidies to District Medical Officers.

Complaints were received from one or two district medical officers as to the Government's action in reducing their salaries, but in no instance could the district medical officers show that they were not being reasonably compensated for the work they did and therefore the Branch was unable to take any action in the matter.

Court Fees for Medical Witnesses.

Drs. Trethowan and Hadley as a sub-committee of the Council interviewed the Attorney-General and urged the Government to revise the list of fees for medical witnesses, *post mortem* examinations, travelling expenses for doctors. The result was that the Attorney-General promised to consider the Council's views. Under the new *Coroners Act* the fees are left to be determined by the Attorney-General and also under the *Coroners Act* all fees for salaried hospital medical officers have been deleted. As this latter is contrary to the views of the Association, Drs. Trethowan and Hadley are being asked to interview the Attorney-General again on this matter, with, it is hoped, beneficial results.

Important Notice.

It was resolved to continue the "Important Notice, Medical Appointments," in the *British Medical Journal* as heretofore.

Honorary Secretary.

During the year Dr. Shearman was granted three months' leave of absence on account of ill health. During this period his duties were very capably carried out by Dr. T. L. Anderson.

After four years' work as Honorary Secretary, Dr. Shearman has decided to retire and not to stand for re-election. I have to place on record great appreciation of the Branch of his excellent services.

Members of Council.

I regret also the decision of Drs. Clement and Merryweather to retire from the Council and not to stand for re-election. Dr. Clement has done ten years' excellent service for the Branch, having been Honorary Secretary from 1909 to 1913 and a member of the Council from 1915 to 1920.

Dr. Merryweather has been a member of Council during the past nine years, during which time he was President in 1916 and represented the Branch at the Cambridge meeting last year. I desire to place on record the Branch's and Council's appreciation of these members' excellent services.

On behalf of the Association I beg to tender our sincere thanks to Dr. Anderson for his invitation for us to hold our meeting here to-night and for the excellent repast we have had. It is much to be regretted that it is not possible for more country members to attend our meetings.

Treasurer's Report.

Dr. W. Trethowan, the Honorary Treasurer, submitted his annual report and balance sheet (see page 410).

The report and the balance sheet were adopted.

Presidential Address.

Dr. A. T. White read his address (see page 395).

Election of Office-bearers and Members of the Committee.

The result of the election of office-bearers and members of the committee was announced as follows:

President: Dr. G. W. Barber, C.B., C.M.G., D.S.O.
Vice-President: Dr. D. D. Paton.
Honorary Secretary: Dr. T. L. Anderson, O.B.E.
Members of the Council: Dr. R. C. Everitt Atkinson, Dr. E. A. Officer, Dr. D. M. McWhae, C.M.G., C.B.E.
Members of the Ethical Committee: Dr. C. M. McWhae, C.M.G., C.B.E., Dr. W. P. Seed, Dr. W. Trethowan.

On the motion of Dr. T. L. Anderson, seconded by Dr. H. H. Field-Martell, Dr. M. K. Moss and Dr. A. E. Randell were elected Honorary Auditors.

Induction of President.

Dr. A. T. White then introduced Dr. G. W. Barber as his successor to the presidential chair.

Dr. R. C. Merryweather suggested that the Honorary Treasurer should supply a statement in connexion with the Medical Officers' Relief Fund (Federal) at the next meeting of the Branch. Dr. Trethowan, the Honorary Treasurer, stated that he would do so.

Paper.

Dr. J. Bentley, M.C., read a paper on "Organo-therapy in Mental Disease" (see page 399).

In thanking Dr. Bentley for his valuable and instructive paper Dr. G. W. Barber suggested that good results might be obtained if patients were subjected to treatment during the early stages of the mental processes. Dr. J. Theodore Anderson stated that organo-therapy had been practised for some years within the institution. He attributed great importance to the early medical examination of school children followed by appropriate treatment. All imbecile children in the institution were being treated with hormotone and the results were being noted.

Dr. J. Bentley, M.C., in his reply admitted that the treatment was not infrequently unsuccessful. They had found that age was no barrier to succesful treatment. In reply to Dr. J. E. F. Stewart, Dr. Bentley stated that they did not usually estimate the blood pressure before the treatment was instituted.

Dr. W. P. Seed exhibited a skiagram of a stone in the right kidney. The patient had passed a calculus 25 years previously and had been free from all symptoms. More recently signs and symptoms had appeared indicating that a calculus was situated in the left kidney. In view of the evidence of the skiagram, the right kidney was explored and a calculus removed.

Medical Examination for Life Insurance.

Dr. L. E. S. Gellé moved:

That in all cases examined elsewhere than in the practitioner's consulting room at the request of the insurance company or its agent, a mileage fee be paid in addition to the examination fee.

The motion was seconded by Dr. J. J. Holland and supported by Dr. J. E. F. Stewart and H. H. Field Martell.

Dr. R. C. Merryweather moved as an amendment that the question of mileage should be left to the individual practitioner. The amendment was seconded by Dr. W. J. Beveridge. The amendment was carried and was also adopted as a substantive motion.

Dr. Gellé moved:

That as regards ordinary offices the fee for medical examination be 21s. except for policies of £500 or upwards, the fee for which ought to be on a higher scale proportionate to the amount of policy.

Dr. J. Theodore Anderson seconded the motion.

The President referred to a communication from the Federal Committee dated September 9, 1919, in which it was set out that £1 1s. should be the minimum fee irrespective of the amount of insurance.

Dr. M. K. Moss considered that if blood pressure readings were required, an increased fee should be paid.

Dr. A. P. Thom wished the fee to be increased.

Dr. W. Trethowan pointed out that the fee was paid for a thorough and conscientious examination irrespective of the amount of insurance. He held, therefore, that the fee of £1 1s. was quite equitable.

The motion was put to the meeting and was lost.

Friendly Society Lodge Practice.

Dr. J. J. Holland moved:

That it be a recommendation to the Council that at the conference with the friendly societies the question of no consultation after 6 p.m. be discussed.

The motion was seconded by Dr. Field Martell and opposed by Dr. E. C. East on the ground that the hour between five and six o'clock was inconvenient for lodge practice. Dr. Moss and Dr. Beveridge supported the motion. Dr. Merryweather thought that each member should be free to fix his own time. The motion was carried.

Frank Edwin Dawson, Esq., M.B., 1917 (Univ. Sydney), of Adelong, New South Wales, has been nominated for election as a member of the New South Wales Branch.

The Honorary Medical Staff of the Hospital for Sick Children, Brisbane, have arranged to hold clinical meetings on the fourth Thursday in each month. The meetings are open to all members of the Queensland Branch of the British Medical Association. At present no definite society has been formed. It is, however, the intention of the members of the staff, if these clinical meetings prove successful, to form a society and to make application to the Council of the Queensland Branch of the British Medical Association for the admission of this society as the Pædiatric Section of the Branch.

Correspondence.

THE "GAUZE PACK" METHOD.

Sir: It will be conceded that one may be permitted to estimate the value of any abortive or early treatment of gonorrhœa no less by its failures and sequelæ than by its successes and on that premise the following statistics are submitted for your consideration.

This series of cases comprises a sequence of those admitted to No. 1 A.D.H., Bulford, and entering one's clinic during 1919, the common factors in such cases being that all entered in the subacute or the chronic stages and that prior to admission all had been submitted to some type of treatment, either argyrol injections, urethral irrigations, supervised or "at home," or "the gauze pack."

For present purposes one may divide the series of 262 cases into:

(*a*) Those previously treated with the "gauze pack," comprising 76 of the cases.

(*b*) Those previously treated by any other method, being 186 in all.

Further, one may consider these two divisions from three points:

(*i.*) The duration of treatment necessary to effect a cure approximating to the "standard of cure" personally satisfactory to Dr. A. M. Gibson, at this time officer in charge of treatment. This was found to be 70.6 days in the "gauze pack" series and 60.3 days in the other class.

Statement of Receipts and Expenditure, for Year Ended December 31, 1920.

	£ s. d.	£ s. d.
Funds in W.A. Bank, 31/12/19:		
War Loan Bonds	325 0 0	
Fixed Deposit Receipts	250 0 0	
Current Account	187 16 10	
		762 16 10
Interest and Dividends:		
On Fixed Deposit Receipts	5 0 0	
„ War Loan Bonds	18 5 0	
		23 5 0
Subscriptions and Capitation Fees		493 19 9
Refund Medical Officers' Relief Fund, stamps		3 12 6
Total		£1,283 14 1

	£ s. d.	£ s. d.
London Office		161 7 6
Medical Journal of Australia		145 0 0
Sundry Expenses:		
Printing	21 3 0	
Stationery	7 17 3	
Postages, Telephone, etc.	25 2 9	
Assistant Secretary's Salary	40 15 0	
Rent of Rooms	2 2 0	
Attendant	2 2 0	
Cheque Book	5 0	
		99 7 0
Dr. Pope Fund: Refund Postages		2 15 0
Funds in W.A. Bank:		
Fixed Deposit Receipts	325 0 0	
Current A/c.	149 7 7	
War Loan Bonds (£410)	400 17 0	
		875 4 7
Total		£1,283 14 1

We have examined the books, vouchers, fixed deposit receipts, and pass book, and certify that the above statement of receipts and expenditure of the Western Australian Branch of the British Medical Association is correct.
March 10, 1921.

(Sgd.) ALLAN E. RANDELL.
M. KASMAR MOSS.

(*ii.*) The incidence of soft or hardening infiltration of the anterior urethra determined at the first urethroscopic examination; that is, the incidence of potential urethral stricture. This was found to be 36.8% in the gauze pack class and 19.3% in the second class. Parenthetically one may remark that the grossest generalized infiltrations of the entire anterior urethra were confined to the "gauze pack" series.

(*iii.*) The percentage of complications on admission to hospital, such complications including epididymitis, acute posterior urethritis, prostatic, Cowper's and periurethral abscesses. The "gauze pack" series showed 20.7% and the second series 20.3%. Of actual epididymitis, the figures were 10.6% and 8.1% respectively.

Yours, etc.,
KENNETH McLEAN, M.D..

105 Collins Street,
Melbourne,
April 28, 1921.

Sir: I have just read Dr. Fogarty's letter re my criticism of his "gauze pack" method of treating urethritis. When Dr. Fogarty's article on his method appeared in the *British Medical Journal* I was greatly interested and followed his technique exactly in my next two cases. I was disappointed to find that they did not get better any quicker than others treated by irrigation. It was shortly after this that I was told by others of their opinion of the gauze pack method. Yesterday I was at a meeting of the Western Medical Association at Parkes, subject gonorrhœa. I was late in arriving but heard a part of the discussion. One speaker said that when at Bulford he had seen cases which had been treated by the gauze pack method and who had what he called a "gas-pipe" urethra, hard and dilated and, what is more important, still suffering from urethritis.

I am still as anxious as ever to know the best method of treatment and if Dr. Fogarty can convince me that his is the best and most expeditious method, I will use it. I wish that others who have tried it would give us their opinions. I think it is rather unkind of Dr. Fogarty to say that I am throwing "cold water on an honest attempt at progress" and that I am not consistent because I did not find his method all that was claimed for it.

Yours, etc.,
J. W. SUTHERLAND.

Narromine,
New South Wales,
April 23, 1921.

SETTLEMENT OF TROPICAL AUSTRALIA.

Sir: Dr. Arthur's letter in your last issue is opportune.

To any man who really knows his tropics (by tropics I mean the moist tropics), the doctor's remarks on the Brisbane Congress and the resolutions passed at it do not come as a surprise when we see by whom those resolutions were passed. We have a gathering of medical men, the great majority of whom live in temperate climates and may at most have had only a fleeting acquaintance with the conditions of life in the tropics and that as a rule at the most agreeable time of the year and under the most favourable circumstances, saying, "We see no reason why Australia as far as its tropical north goes should not be developed by the white." By white I presume they mean the Anglo-Saxon, for that is the class of white we really want in Australia and generally think of when we say "white." Speaking from experience, and after a few years in the tropics—and that with the assistance of my native servants to make life comfortable—I cannot conceive it possible to develope any moist tropical country without coloured help of some sort to do the drudgery. We must remember this, that after all it is not the man alone that developes the country to thick population, but the woman. It is the woman who carries the baby, it is the woman who has the drudgery of the house-keeping, it is the woman who rears the children, and it would be a good thing for all of us if we looked to her side of the question a little more. Talk to any one of these men who have so much to say on the development of northern tropical Australia and what do you find? Either that they are not married, if still in the tropics, or they speak of isolated cases which have succeeded. If you suggest that as they are so strongly in favour of opening up this country entirely by the white, then they had better go there themselves, and take their families, they turn to you and say, "Oh, I am past the age," or "I am doing all right here," or "Oh, let the returned soldier take land up there." Yes, it is always the returned man for the dirty job. He has not only to fight for you abroad, but he is to go in and rough it again up north, whilst you sit down in comfort in a temperate zone. I am thankful to say that though I enjoyed my years in the tropics and did good work there, as a single man, my wife had enough common sense to say, "If you intend to carry on your work entirely in tropical countries, then I will not marry you, not only for my own sake, but for the sake of any children we may have, for I know it would mean a life largely of separation if the health of myself and our children is to be maintained"—and this, mind you, in countries that are not devoid of native labour to do the housework. From a poetical and theoretical point of view the "White Australia" is good—every one of us agrees with that—but that it is going to be practical in the moist tropical north, well, honestly I do not think any resolution passed by the Medical Congress at Brisbane is really worth a snap of the fingers on the point. You must get your opinions from the men and women who really know their tropics and the conditions of life in the tropics, to be of any real value, and not from casual visitors. I am certain of this, all these people who know, will say you must have help of some sort and that help will not be of an Anglo-Saxon breed. There are exceptions undoubtedly, but they are very few, and it is numbers we want if the country is to go ahead.

Yours, etc.,
R. W. HORNABROOK.

Melbourne,
April 26, 1921.

PRELIMINARY EXAMINATIONS AT THE MELBOURNE UNIVERSITY.

Sir: May I amend the statement in your Education Number (page 374) concerning conditions of entrance to the Medical School of the Melbourne University. Candidates qualifying in Victoria for entrance must have passed both the intermediate and the school leaving examinations. Intermediate Latin and geometry are compulsory, unless the Faculty of Medicine grants a dispensation, which is given when candidates have obtained honours at the school leaving examination in one language and one other subject. Candidates qualifying in other States for entrance must have passed examinations approved by the Faculty of Medicine.

Yours, etc.,
H. B. ALLEN.

The University of Melbourne,
May 4, 1921.

NOMS DE PLUME AND ANONYMOUS COMMUNICATIONS.

Correspondents from time to time send us anonymous communications often dealing with matters of considerable interest. Unfortunately, no notice can be taken of these letters unless they are accompanied by the writer's card or by some other indication of his name and address.

Correspondents are also informed that the habit of sending letters for publication in our columns over a *nom de plume* should be avoided except in special circumstances. The expedient rarely serves a useful purpose and is frequently inadmissible, especially when the subject discussed involves a question of policy or includes a personal reference.

It is announced that Dr. Robert Fowler, O.B.E., has been appointed Surgical Clinical Assistant to Out-Patients at the Alfred Hospital, Melbourne.

Dr. F. A. Bennett has been appointed a Director of the Sydney Hospital. A vacancy occurred recently through the death of the late J. Garland.

Books Received.

BLOOD PICTURES: An Introduction to Clinical Hæmatology, by Cecil Price-Jones, M.B.; Second Edition: 1920. Bristol: John Wright & Sons, Ltd.. London: Simpkin, Marshall, Hamilton, Kent & Co., Ltd.; Demy 8vo., pp. 64. Price, 6s. 6d. net.

THE PHYSIOLOGY OF PROTEIN METABOLISM, by E. P. Cathcart, M.D., D.Sc., F.R.S.; New Edition; 1921. London: Longmans, Green & Co.; Royal 8vo., pp. 176. Price, 12s. 6d. net.

THE DIAGNOSIS AND TREATMENT OF INTUSSUSCEPTION, by Charles P. B. Clubbe, L.R.C.P., M.R.C.S.; Second Edition; 1921. London: The Joint Committee of Henry Frowde, Hodder and Stoughton: Sydney: Angus and Robertson, Ltd.; Demy 8vo., pp. 91. Price, 7s. 6d. net.

TREATMENT BY HYPNOTISM AND SUGGESTION OR PSYCHO-THERAPEUTICS, by C. Lloyd Tuckey, M.D.; Seventh Edition; with a Chapter on Treatment by Suggestion During the War, by A. Percy Allan, M.D., B.S.; 1921. London: Baillière, Tindall & Cox; Demy 8vo., pp. 413. Price, 21s. net.

ADVANCED SUGGESTION (NEURO-INDUCTION), by Haydn Brown, L.R.C.P., etc.; Second Edition; 1921. London: Baillière, Tindall & Cox; Crown 8vo., pp. 402. Price, 10s. 6d. net.

CLINICAL BACTERIOLOGY AND HÆMATOLOGY FOR PRACTITIONERS, by W. D'Este Emery, M.D., B.Sc.; Sixth Edition; 1921. London: H. K. Lewis & Company Limited; Demy 8vo., pp. 310 with 66 illustrations, including 11 plates. Price, 15s. net.

THE CLINICAL EXAMINATION OF DISEASES OF THE LUNGS, by E. M. Brockbank, M.D., F.R.C.P., and Albert Ramsbottom, M.D., F.R.C.P.; 1921. London: H. K. Lewis & Company, Limited; Crown 8vo., pp. 58 with 13 illustrations. Price, 4s. 6d. net.

DIATHERMY, its Production and Uses in Medicine and Surgery, by Elkin P. Cumberbatch, M.A., B.M., M.R.C.P.; 1921. London: William Heinemann (Medical Books), Ltd.; Demy 8vo., pp. 192, illustrated by 38 figures and 44 plates. Price, 21s. net.

AN INTRODUCTION TO CHEMICAL PHARMACOLOGY; Pharmacodynamics in Relation to Chemistry, by Hugh McGuigan, Ph.D., M.D.; 1920. Philadelphia: P. Blakiston's Son & Company; Demy 8vo., pp. 418. Price, $4.00 net.

BIBLIOGRAPHIE DES LIVRES FRANCAISE DE MEDECINE ET DE SCIENCES, publiée par La Section de Médecine du Syndicat des Editeurs; 1908-1921. Paris: Hotel du Cercle de la Librairie; Demy 8vo., pp. 146.

Medical Appointments.

Dr. H. V. D. Baret (B.M.A.) has been appointed Assistant Medical Superintendent to the Coast Hospital, Little Bay, New South Wales.

Dr. A. W. Esler (B.M.A.) has been appointed a Public Vaccinator at Eaglehawk, Victoria, and Dr. C. G. Godfrey (B.M.A.), a member of the Midwives Board of Victoria.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxiii.

University of Melbourne: Cancer Research Scholarship.

University of Adelaide: Professorship of Zoology.

Alfred Hospital, Melbourne: Medical Superintendent.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C..

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIA. (Hon Sec., Medical Society Hall, East Melbourne.)	All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Ancient Order of Foresters. Hibernian Australian Catholic Benefit Society. Grand United Order of Free Gardeners. Sons of Temperance. Order of St. Andrew. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

May 17.—N.S.W. Branch, B.M.A.; Executive and Finance Committee.
May 17.—Illawarra Suburbs Med. Assoc. (N.S.W.).
May 18.—W. Aust. Branch, B.M.A..
May 20.—Eastern Suburbs Med. Assoc. (N.S.W.).
May 24.—N.S.W. Branch, B.M.A.; Medical Politics Committee; Organization and Science Committee.
May 25.—Vic. Branch, B.M.A., Council.
May 26.—S. Aust. Branch, B.M.A..
May 26.—Clinical Meeting at the Hospital for Sick Children, Brisbane.
May 27.—N.S.W. Branch, B.M.A..
May 27.—Q. Branch, B.M.A., Council.
June 1.—Vic. Branch, B.M.A..
June 3.—Q. Branch, B.M.A..
June 8.—Melb. Pædiatric Society (Vic.).
June 10.—N.S.W. Branch, B.M.A., Clinical.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4635.)